Clinical Quality Workgroup
Draft Transcript
April 18, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Standards Committee's Clinical Quality Workgroup. This is a Federal Advisory Committee, so there will be opportunity at the end of the call for the public to make comment. Workgroup members, please remember to identify yourselves when speaking.

Now, let's do a quick roll call. Jim Walker?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Kmetik? David Baker? Anne Castro? Chris Chute?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bob Dolin? Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky? Gene Nelson? Eva Powell?

Eva Powell – National Partnership for Women & Families – Director IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Philip Renner? Sandy Rosenthal? Joachim Roski?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Rosemary Kennedy?

Rosemary Kennedy
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tom Tsang?

Tom Tsang – ONC – Medical Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jon White?

Jon White – AHRQ/HHS – Director IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Patrice Holtz?

Patrice Holtz
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Aneel Advani? Did I leave anyone off? Okay, with that I'll turn it over to Jim Walker.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Thank you all for joining. Today we are going to continue with Floyd Eisenberg's review of the quality data model, and as you probably remember, we have two questions before us, or two sets of questions. One, is the quality data model adequate for managing the information we'll need to manage to develop, communicate, and curate? Particularly in what ways does it need to be modified to be fully adequate, if there are any? Then the second question is, what kinds of recommendation does the workgroup have for ONC as it manages the contract with NQF to develop and maintain the QDM going forward?

Then the second topic at noon relates to the May 19th hearing on people's experience with meaningful use stage one. We are co-sponsoring that hearing with the Policy Committee Quality Workgroup. I think the things that would be useful for us to start talking about today and for you to both talk about in the meeting but also send us recommendations off line as you think of them, are which stakeholders' groups need to be represented and who specific panelists for those panels might usefully be. So I think Floyd's on and everyone has the Excel spreadsheet. Floyd, are you going to explain to us how that may support us as we listen to your presentation and think about the QDM?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes, sure. Just so everyone knows, for the workgroups there were three documents sent out this time. They included an Excel spreadsheet and that had on it three worksheets. The three worksheets included QDM evaluation, the other was measure readiness evaluation, and the other was taxonomy by two different concepts. The other two were an overview of the QDM, that's a draft that will be published and publicly available on Wednesday the 20th, in two days. The third document was a technical specification that got into more detail of that ... slide.

If we look at the spreadsheet, basically if I can give a recap, and I can try to discuss this quickly without slides, the QDM itself is a structure. Each QDM element has a concept or category of information. Those concepts, if you look at your spreadsheet, are listed in the third worksheet under "Taxonomy by QDM Concept." So they have allergies, characteristics, basically personal individual characteristics, communication device, medications, lab tests, are some of the examples. There are 23 concepts, each of which is then, in order to state the element, incorporates in what action is expected to be present for the measure, so state of action or in how it's to exist, is it active, is it inactive, say, for a problem. That is combined then with a value set which is derived from a code set or a vocabulary that is specific to that type of concept. That's the QD Instructor.

So if you look at your spreadsheet—and starting with, I'll actually start with the third worksheet, if you would like, which is basically for every concept what are the taxonomies, or code sets, or vocabularies

currently specified in certification. And which ones were used in retooling because of other factors, either discussion with the Standards Committee earlier, or discussions in HITSP or other organizations. That was what was used and, as you can see, a number of the concepts I may have missed on, but do not have specific code sets or vocabularies to which they were assigned in a certification rule. That's the first piece we can represent for discussion.

The other is in the documents, and I realize they were sent Friday and not everyone will have had a chance to review them all. We did provide how we took any individual element and related it to another to create basically a clause or a phrase. So if we wanted to say that a condition or diagnosis was present at the time of encounter or before the encounter we would say it starts before or during the encounter. So the, "starts before or during" is a set of words that were used to combine them, and they were derived from the HL-7 version three so that we use standard concepts to do that comparison. If you look at your spreadsheet, there is, in the measure QDM evaluation, if you look at all of the measures listed across the top they were some of the recommended measure statements for stage two. In actually evaluating these, if you look at the technical document that you received, starting on page 19, at least the care coordination measures provide us an example of how the QDM could be applied to it.

I'll ask you, Jim, if you would like me to refer to a specific example and I could attest for the technical document to do that, or how do you want to proceed?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think, Floyd, although I'd welcome comment, that we ought to take one of the recommended measure statements and just walk through what it would look like in QDM as a way of thinking as carefully as we can about what QDM does and what it may need to do that it doesn't do.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Okay.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
If I could have a request.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, please.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
You've given a great deal of attention to value sets, but looking quickly at the spreadsheets and related activities, as you no doubt know, you're really restricted to target vocabularies. So where and how are you representing the value sets, and more pertinently how are they being provided?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Actually, let me ask for two things. I know the folks managing the call are able to pull up the slides that I used on the 7th, and if you could pull those up and go to slide 11 and I can describe that for you, Chris. As you see on slide 11 here, where we had the concept and the states, so the state eager for this medication and the example was administer. Then the value set is incorporated within the QDM element by, the QDM element is provided in the measure as a pattern taken from HL-7 version three to be able to indicate that medication is administered and in that refers to an object identifier, an OID registered with HL-7, an HL-7 OID from the measure developer. That refers to the value set of all of the codes in RxNorm for ASTM. That's how it would be applied. Since there was no existing value set registry that was defined for us to use, in the measures we provided an Excel spreadsheet of all the value sets used for each particular measure and it included not only the values, it included the merging of the taxonomy or co-set and it included the descriptor where we could provide one. Does that help answer that question?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
That's hugely helpful. Thank you, Floyd.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Do you have any other questions before Floyd continues?

Aneel Advani – Indian Health Service – Associate Director Informatics
Floyd, I had a question, who does the work on the QDM so far, who does the tooling of specific test, ..., have you looked at any of the ...hospital measures at all for MU in this context?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
The sound was breaking up a little bit, but I believe what you were asking is have we looked at the hospital measures. In the retooling process, the 113 we worked on last year, there were a number of inpatient measures. There were some for pneumonia, many of these are the ones that are currently on hospital compare, so AMI, myocardial infarction, pneumonia, surgical care improvement projects, ..., and I believe we also, I'm missing one, I can't tell you why I'm missing the fourth. But there were actually four types of measures in the hospital, and they were retooled using this model. Does that help?

Aneel Advani – Indian Health Service – Associate Director Informatics
Yes, that's very helpful. I think there's a separate issue of the specific MU related ... hospital measures and where that will start hitting our electronic measure tooling process. But that's a topic for not specifically this discussion.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Right.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Any others before Floyd goes on? Okay, Floyd.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
So given that, are you able to pull up the technical specification document, or if not I can ask folks on the committee, if you go to page 19 of that document what I did with that was—Jim had actually provided a question about a measure. So this is not one of the ones in the stage two that are specifically listed. And that was could we express a measure that says basically all patients who are taken into a practice with a new diagnosis of hypertension, can I determine how long it takes to bring the diastolic blood pressure from elevated to less than 90. You'll see that's what we tried to do here, and there are two versions. One is a new intake to the practice, and the other is a new diagnosis for an existing patient. They're slightly different because of how the denominator is defined. The third measure is related to care coordination and sharing of data from the primary care to the specialist, the consult back to the primary care and shared with the patient.

So understand these are simple attempts to define a measure. These are not endorsed measures. They are not out there for endorsement. They're just trying to, based on the concepts, show how these could be expressed. There will very likely be different concepts you'll want to address in the measure and I can discuss how the QDM can handle those. But I had to start with a straw man. Jim, would you rather me start with the blood pressure or the care coordination?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Whichever makes sense to you, Floyd.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Since it's in the meaningful use I'll go to the care coordination, it's on page 21. Not that there's anything wrong with the other one, but that's on the Excel spreadsheet. The statement was expecting a composite measure looking at referral those composite measures assessing success in a bidirectional manner between specialists, primary care physicians and patients and to address transfer between the physician requesting referral and consultation and the provider completing it, and in addition communication with the specialist and the patient. What I created here is an example using the QDM with using the concepts of, now it doesn't ask for age, but most measures do deal with adults, so I started with a patient characteristic birth date. Now it could be that you don't want just any patient, so it could be any age, but I had to start somewhere.

The action on the characteristic is that it has been documented that there is a birth date. In order to be able to create this kind of measure, QDM has now, going out for comment in the new version, something called a "health record component." So in this case we're thinking of a consultation referral as the component and a consultation report is another component, and in both cases we want to know that it was transmitted. I could also ask that it was acknowledged, that just happens not to be designed here, but we can evaluate acknowledgment as well. So the measure basically for the population says all patients over 18 before the measurement period begins, so they are adults. It doesn't have to be 18. It can be any year you'd like.

Going to page 22, where it continues the denominator ... and there is a health record component transmitted. That component is called a consultation referral. In here the data flow attribute, and we described some of the attributes more clearly in the technical component, there's a whole glossary that defines these, that the sender is the primary care physician and the source is the physician and the recorder and the subject is the patient and it occurred during the measurement period. So for all those where there was a referral transmitted basically, then numerator one asked for, and the receiver, the specialist of the health record component has received it. The health record component received, data flow attribute indicated by the specialist physician, and the source of the document that was received is still the primary care physician. The subject is still the patient.

I created a second numerator indicating that for all those who have had the transmitted consultation there actually now is a report, record component transmitted consultation report, sent by the specialist and the second one also received by the primary care physician. Rather than making it more complex just saying and also a copy was received by the patient, and that's where I have the third one, the data flow is receiver equals patient. So it was a simple version of the measure. We can add to it that it's trying to explain how we can identify that something has been created, has been sent, has been moved and received. I'll stop there and ask for comments.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Floyd, in some settings, there might be an automated referral. If a patient's glomerular filtration rate goes below 60 an organization might have a policy just automating referral to nephrology. I guess in that case the primary care physician to whom the result is going to go would be listed as the one sending the referral. Can QDM manage that?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Well, you could indicate that the source of the referral is the system.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
So it could be a policy? Okay.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes, and that was basically an implementation. But it could indicate that the EHR submitted that was the source of the information or the reporter, if it wants ....

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
And in that case you need some concept of someone who's going to be the recipient of the result even though they might not have been the actor ordering it.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes, so what the QDM allows you to do is specify, and it could get as granular as the electronic health record, was the sender, that a personal health record was the receiver, and request acknowledgment from the personal health record and request acknowledgment also from the individual, so it lets you do that. The trouble is implementing it and making sure that EHRs, PHRs, and others can provide this kind of information. The QDM was enhanced to be able to describe what was needed.

Rosemary Kennedy

Floyd, just a question, I think you may have answered it in the prior use case example. A referral may go through multiple parties before this addition and after this addition. So QDM could handle that just like you do here, there would be multiple parties, it would just be offered in AND as it goes through various states through multiple parties. I'm just thinking, I'm taking you out of this example a little bit, but I'm thinking referrals that maybe go from acute to home care and kind of go through multiple parties.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Rosemary, you're absolutely right. I think the question for a quality measure is how much detail and how many steps it wants to look at. Or, is it acceptable to look at coming from anyone that a referral was sent and received and make sure the human actually saw it, as opposed to a system, or do you want to specify every step in a care coordination model as it went from a physician to the care management nurse to someone else. Each one of those can be specified, absolutely. It's all in the measure design.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
I was looking again at the conceptual definition of care coordination on page 21, and then trying to see how the information got back to the patient, and under numerator two, can you explain a little bit more about how the verification that the information gets back to the patient is done? How is it sent and how is the receipt known?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
The first thing I'll say is the definition of care coordination came verbatim from the recommended measures statement that I was provided. I appreciate the question and after we sent this I thought I probably could have included a few more elements, which would address exactly what you're looking for, it was a matter of how detailed I wanted to make the example. What this is just saying is a report was received by a patient, but how do I know that? We can additionally have an "AND," the healthcare component acknowledged consultation report or summary and that the attribute there would be the receiver would be the physician or electronic health record and the after source of the acknowledgment would be the patient. That would be an additional element to know it was acknowledged.

I recognize it's not here, but the QDM can handle it. It's a matter of designing the measures to make sure what you're looking for. Now, how do you know that it's been acknowledged? An acknowledgment would need to be sent from either within an EHR if they're working through a portal, or from a PHR, and the acknowledgment maintained by the original EHR that was managing it. But this is to define that and then to identify where there may be gaps in standards or harmonization required for how acknowledgment is manifested and managed.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
I understood what you said and I was trying to, I think, get into the territory that you were just moving into—that as you move into the future, 2013, 2015, being able to have two-way communication between, or three-way communication in this context, primary care physician, specialist physician, and patient, that there's an ability to interchange that information electronically and how the QDM accommodates that. Thank you.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Thank you. Actually, just so folks understand, the health record component concept is derived from the health IT assessment framework expert panel report that we worked with the panel on the last year, in 2010, which describes for any to know that EHRs or clinical systems that they use in a certain way requires a combination of an actor, action, and content. Here the content is the consultation report, that's why we created the health record component in QDM. Depending on which element you're looking for in the numerator, the actor is either the patient, the specialist, or the physician, and the action is either receive, transmit, acknowledge, or one of the other actions we have in that category, using that concept from the technology assessment, the HIT assessment framework to apply it to actually use it within measures.

Rosemary Kennedy

So that health record component then takes on various states. So if I, the patient, I can acknowledge that I received the report related to the referral, or I could even recommend or provide feedback. So that's how the health record component would be used to facilitate the care coordination for those various states.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
That's what's proposed here, yes. So if you do look in the two documents that you have, the draft that will be published on Wednesday, in the overview it lists all of the potential actions and in the technical specification actually defines each of these. So there's also a table that defines for each concept, in this case health record component, all of the actions that can be used around that. There are about 19 actions that can be used for health record components. Among them is record, transmit, acknowledge, receive, and I forget, there was another word you said that's also in there, I don't remember from your comment.

Rosemary Kennedy
Recommend?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes, recommend is one of them.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I suppose modify is another?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
It is.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Okay, great. So, are there questions for Floyd about—I think one of my goals for today at least is to come pretty near final resolution on the workgroup, whether the workgroup feels that the QDM can be recommended as it is to the Standards Committee as being a useful and comprehensive tool for managing e-Measures or not. So are there any other questions or comments that bear on that?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Jim, let me just comment. You said modify, we included update instead of modify, but it is, just to clarify.

W
I just had a quick question, and the best I can think through this on the fly I think the answer is yes, but all of these examples seem pretty specific to an individual patient but in the future we're going to need population measures as well. Will this accommodate that with the current categories? And looking through them it seems like it can, it would just be the actor might be, say, a registry or some other entity that perhaps we're not thinking about specifically now. But it still could sit within the confines of the category. Does that seem true to everyone else, or have you, Floyd, taken this through a population kind of perspective in terms of an example or a use case?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
We haven't specifically applied it to a population use case. Most of this model is based on a framework developed in concert with our expert panel, the HIT Advisory Committee, that incorporates population measures in its thinking and it includes the ability to add environmental factors as well as individual characteristics, and I believe it will handle it. I would be happy to run a use case through to check it and evaluate it.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards
At least on that point, is not population at some level aggregation of individual metrics? Now, granted you have cohort definitions and the like which are not covered here, but in terms of the contributions to the aggregation, it's really based on individual measures that are aggregated, aren't they?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
In most cases that's what we're seeing, right.

Aneel Advani – Indian Health Service – Associate Director Informatics
I have the issue of is this sufficient for management of sets of e-Measures, I have two questions. Some of the phrasing of some of the stage two—or at least one of the stage two—criteria or objectives includes a reference to evidence-based information. I'm wondering if there was any thought or if somewhere in the QDM there's a way to tie the definition of a measure or an e-Measure to assumptions about evidence that would then allow us to evaluate or retract or assert that that evidence was now invalid or valid. Therefore allow us to manage measures in relation to evidence support.

Then the second issue, sort of related to that, is in situations where measures are particularly appropriate for particular sub-populations or ethnic populations, or if you have comorbidities which would make particular measures require to be adjusted or have exceptions. I'm wondering if you've incorporated that at all in terms of relationships between closely related measures where there might be dependencies with a certain more general measure to a more specific one, which incorporates adjustment or exception. So those are two separate questions.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Let me try to make sure I remember both. The first question, my memory –

Aneel Advani – Indian Health Service – Associate Director Informatics
Evidence support and whether you link it up.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
In each e-Measure the e-Measures are basically using the address standard ... from HL-7 the e-Measure representation of the health quality measure format, and in that format the header of the measure, which is not part of the QDM, but the header of the measure includes fields for evidence clinical recommendation statements and background and references. In the endorsement of measures as they come through NQF there's a clear review of the evidence with steering committees and with public comment to be sure that the components of it are based on evidence. The QDM itself does not have a specific evidence-based piece to understand that a role is evidence-based or that a measure is at this point we have left that to review of the background information about the measure and how it was developed and the endorsement process. So that's where that stands today. I'd be interested in talking about how it might otherwise be managed.

When it comes to the stratification, you're talking about, the patient characteristics component category or concept allows definition by ethnicity, race, and socioeconomic status, whatever patient characteristics you're looking for, it may be geographic. In doing the retooling what we found last year, we found that they could either be different measures with a different population but more easily handled. We handled the measures as different populations within the same measure to be able to stratify all and then most of the stratification and the metrics that were done with age. So it was all patients within an age range and then those within a subset of the age range, those within a different subset. So it can handle those. And just like different age ranges, it can handle based on different social and other characteristics.

W
Oh, did you have another question?

Aneel Advani – Indian Health Service – Associate Director Informatics
I did have one more, but I don't want to take up the whole time. Maybe just answer briefly, and if you can't answer briefly that's fine. The statistical stability of quality measures can sometimes be dependent on how large a population you're applying them over. So for instance if you do physician profiling with an inappropriate measure where most physicians are only seeing five cases of that type of patient per year, it's going to be completely statistically unreliable. Is there some element in the modeling language here that you've put in to have sort of a stop point or a break point where if suddenly the measure is now being

applied to too low an ... it comes out with indeterminate or something appropriate based on the physical stability properties?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
It's a great question. Actually, there are three ways the health quality measures format can be expressed. One is a population measure that is continuous variable, so it's without a population and in there you could specifically state minimum population out. There's also ratio and there's proportion. In the proportion measures, which is predominantly what we worked on mostly, they are based on an individual patient experience, or, I shouldn't say patient, some of the focus of the measures is a procedure or a hospitalization. But it's based on an individual unit of analysis and then they are aggregated. In the aggregation information, which in the measures we've done has been applied in the guidance section, it can certainly indicate that. The logic itself is it's looking for an individual instance of the unit of analysis would be difficult to, I would look for advice as to how we would be able to say you must have at least five of these. I think that's a higher-level piece of information for implementation.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Floyd, if I understand you, you're saying that, and I think that's a great comment, by the way, that somewhere for every one of the e-Measures we ought to say this size population is required for legitimate interpretation of this. The question then is where would that datum be? Would that be part of that evidence base? You can imagine it would be part of the evidence rating that I think appropriately you said is prior to QDM. Is it part of that process?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I believe it is. If a specific yield is needed in the health quality measure format to indicate minimum population size, that's a perfectly good comment, in fact, an excellent one, that we can make sure feedback ... HL-7 to get it in the standard and in the meantime we can use the user field to incorporate that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Okay. Yes, I think we really want to make sure that we drive that through. That's a great point.

Aneel Advani – Indian Health Service – Associate Director Informatics
One other way is just to have some sort of indeterminate truth-value. In other words, it's the same issue with missing data as well, so if you have just people are not recording an element that the designer thought should be part of the measurements of actually ... what assumptions ... whether people are actually following or not following are sort of similar. Anyway, ...technical issue, but just related ....

Eva Powell – National Partnership for Women & Families – Director IT
....

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I'm sorry. Can I make just one more response? Is there time?

Eva Powell – National Partnership for Women & Families – Director IT
Sure.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
In some of the measures that we've re-tooled, the measure developer specifically wanted to know how many had missing data, so they created basically a second numerator that was not to be calculated with the measure and that's indicated in guidance, but what we do need is a way to specifically specify don't use this for calculation, just for reporting. There is a way we might be able to fit that into the final HQMF.

Eva Powell – National Partnership for Women & Families – Director IT
Just a quick question or maybe comment based on the conversation before about the minimum population necessary to interpret results. I think that's really important, certainly from the perspective of reporting or holding providers accountable.

My comment then would be, and it's along the lines of what actually belongs in the QDS, because what I wouldn't want to do is to put that kind of information into the QDS if the QDS is intended to drive quality measurement for multiple purposes. In other words, yes, measures need to be of a certain level of robustness in order to report or hold providers accountable, but if we're just talking about providing feedback information to providers to make improvements, that level of robustness and the population size matters much less. I would not want to preclude the information of QDS being used for that second purpose, not secondary purpose, but the second one that I mentioned, because of having information about well, you can't use this measure unless you've got "x" population. I guess the question from that would be, is the QDS intended for all purposes of measurement or is it just intended for reporting and accountability? I think my understanding had been the former, that it's a tool to use to create measures, not necessarily to decide what those measures are then used for.

Second is that population information or the minimum population information necessary to put in QDS or is that a job, as was mentioned earlier, for the evidence generation prior to the development of the measure and then the application of the measure and development of the measure on the back end using the tool of QDS. I'm sorry, that was a mouthful.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
No, thank you. I think that was a useful discussion. Any other thoughts on either this topic or others about the adequacy of QDM, anything else we would need to—?

Marjorie
I just wanted to raise a question, in making our recommendation who's the target audience for the QDM? This is a model that someone will use and I think it's for a pretty sophisticated audience and I'm not sure we captured who or landed on who that audience is.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Good point. I think Floyd has a pretty good idea, but I think it would be smart to make it explicit.

Marjorie
As we're making our recommendation I think we need to be really clear about that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, I agree. Floyd?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I also agree. I think the QDM really is a model targeted to those who are seeking information from electronic health records, electronic data sources, clinical data specifically, I shouldn't say just clinical, but data, so it's really quality measure developers but I don't think it's limited to them. There are folks in individual hospitals and other organizations that want to do measurement of certain activities and the QDM certainly can be applied to those, but they're usually the technical folks who understand the information they're looking for and define it well. The same for clinical rules for decision support, their developers as well.

Marjorie
This is where I think it's sort of a mismatch. I think that it certainly is a technical individual that would use the QDM, but they tend to be on the vendor side of things. Developers, in my experience, and just speaking from mine, tend not to be that technical audience. So this is for someone who's developing a measure so that you have some kind of electronic rendering of the measure at the end of the day, correct? Do you see what I'm saying? So we're developing a technical model for, I believe, individuals that we don't have a large group of technical users to use them on.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
This issue has been raised in other forums. I think part of the implications of this discussion are that guideline developers and quality measure developers have a higher bar to meet than they used to. It

used to be you just kind of shot your mouth off and let somebody else worry about what they were supposed to do with it. I think part of the logic of the discussion now is that if you want to develop a guideline that you actually intend to see put into practice. Certainly if you're going to develop quality measures, you just need to get someone on your team who can help you represent this in what is a fairly simple data model or nobody will be able to understand it or do anything with it.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Just to add to that, I think what we're also doing is developing an authoring tool to enable use of the model without having to understand all of the technical details we intended and try to make it somewhat simpler. But the tool itself is a tool. It isn't everything. There's still some education that I think we can expect ... to help move in that direction.

M
Could you comment on if anybody has, I understand the expert panel input on this, have organizations that are prospectively used this tool to offer measures they were interested in and shared their experience with you?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Not directly. It has been used more in the context of taking measures that were and retooling them into what we now have. There hasn't been as much de novo I want to create a measure, how do I want to work it through? With that said, though, one of our data testers of this authoring tool, actually three of them, are not routine measure developers from an AQF standpoint. There's an accrediting body for physicians, there are two hospital systems, and they are using it and testing it to try and understand it and actually create some new measures and put them in and try it to make that happen. We've also had feedback from a number of folks who are working on decision support and using the QDM to help define the input data they need for a decision support role and the presence or absence of any one of those elements at a specific time could represent a trigger for the role. So we do have some doing that, and actually from the decision support side some very strong interest and use of the QDM for that. But it is still early.

Rosemary Kennedy
Floyd, just to your point, we're using the QDM at our facility and the folks that we have engaged are not necessarily just the quality technical folks, but we have quality and performance improvement staff. It's given us the ability to bridge those people with the HIT designers at the facility, because there are probably multiple levels of design, one done by the vendor and then the second way is done by the facility. So we're looking at the coordination of care from acute care to home care and using the QDM as a backbone to help us design a system that supports the operations of the coordination of care as well as the measurement of the performance of that care coordination in anticipation for more specific measures that may come out in the future. I don't know if any other facilities are looking at it from that perspective, if you could speak to that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Was that a question for me?

Rosemary Kennedy
Yes. Just a question that from a provider perspective, not just vendors, not just technical staff, but quality management folks combined with IT designers, and we're using QDM to set up an IT infrastructure for coordinating care from the acute care to home care setting.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I had not heard that specific feedback from others, but I do know that it is the defined group within facilities, and I've talked to a number of facilities that have the interest to do that. I haven't heard as specifically as your comment that someone's actually doing it, and I'm encouraged to hear that. But I've had a lot of interest from back to the quality and performance improvement organizations within hospitals, those departments, to try to define data to do their own analyses as well. That's why we made sure to incorporate not only the measure developers as we think of measure developers, but also some hospitals

and some other types of organizations in testing the tool to make sure it's usable, but as they test the tool they're also testing QDM.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
Floyd, I think I raised this question the last time we talked. How does the QDM handle measures of harm?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Measures of harm, it's an excellent question. What I'd be very interested in is thinking through some specific use cases to see how we could apply it. I think the challenge in measures of harm are if you're looking for potential harm that was avoided, then what is the factor you're looking for that represents the potential for harm? If you're looking for harm that existed and that actually occurred, that can also be defined somewhat, but we have to look at the use case. In some cases all of the data you may require may not exist in routine electronic sources and may be in separate risk management databases.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
I was probably more thinking of harm whether or not it could be judged to be avoided or not. A place to start would be the ACO proposed measures under safety, which has a fairly long list of patient safety indicators, some of which are harm measures.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
You're absolutely right. I believe it can. I can't know everything until they actually go through the use cases and ... but I believe it will be able to cover that as long as the elements can be defined clearly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
We have an AHRQ funded study of one tool for reporting and aggregating cases of health IT associated hazard and care process compromise and harm. My question here is, do we think this is in scope for QDM or another mechanism? It seems to me we could, we have an extensive ontology and a whole set of ways of thinking about this, and you could think about the AHRQ common formats also, but I wonder if that's a separate set of activities and would be redundant if it were in the QDM's model. That's for discussion. Any thoughts on that? Chris, you're used to thinking in terms of how to organize things like this so that they are comprehensible and cogent, any thoughts? All right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Can I give a suggestion?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Oh yes, please.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I think that in some of those cases there is information that a routine clinical care process won't necessarily have. If I'm caring for one patient, as an example, I don't generally expect to document in the record if there have been other similar incidents within the last month. So thinking in comment formats, that's one of the things that they ask, so some data just wouldn't necessarily be a routine part of clinical documentation, nor really should it be necessarily. But there may be ways to use QDM to capture data to fill or pre-fill some of the information you need in either comment formats or your template if you can map the models, but I don't know it would give you everything you need.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Okay, so you're going to take it back and do some thinking about that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I think it would actually be an interesting project to do that analysis, and I think it could be done if that were defined.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, someone was about to comment again?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
This is probably a general comment. A quality data model connotes that we have a shared definition of quality and there's more than one definition of quality, IOM attributes of quality, safe, timely, efficient, equitable, patient centered, and that's where I was coming from with the harm question and seeing if it's safe with respect to harm avoidance. Floyd, have you had a chance to, you probably have, to run those attributes against the quality data model safe, timely, efficient, equitable, patient centered?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Actually, that was part of what helped create it. So, yes, and that's actually what our HIT advisory committee used as its basis in creating the framework we worked under. So, yes, we have. What I haven't had the opportunity to do is go through, say, all of the comment formats or the process that Geisinger has created and see which of the elements they have are actually mappable directly to QDM so that they can actually extract data into the format and then ask just what's additional that's needed. But that hasn't been done.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I'll send you the ontology, Floyd.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Okay, great.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
What about equitable, equity's critical but is that in the scope of this? I would think there again—well, I guess feeding in a population sense.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
That's where defining patient characteristics, socioeconomic status, region, etc., lets you define disparities, which then lets you evaluate equitable care.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I guess that's the same answer, that the QDM needs to be able to capture data that would be used elsewhere to assess both safety and equity.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I believe so, yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Gene, does that fit what you're saying? Is that reasonable from your standpoint?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
Yes, I think it is. I'm very impressed with what I understand about the QDM. It looks like very good work and I'm trying to find holes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
No, that's great. That's what we're here for. Just keep it honest.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I wanted to throw out, I haven't thought this through but I'm wondering, does the model work for surveillance, say? I'm taking this outside of quality measurement per se, but let's say the CDC is trying to track something, would they be able to use this? Floyd, do you have any feedback from them by chance?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I had some discussions with some folks at CDC and if there are any on the phone perhaps during the public comments they can add to this. There has been significant interest in extracting data that can be

used for surveillance by requesting those data using a standard model. That even when we worked our retooling the central line associated bloodstream infection, the … measure, and there was one for urinary tract infections as well. We had the discussion about how the National Health Safety Network surveillance system, to make sure that at least the value sets used for each of the components and to make sure we had definitions consistent dealing with the QDM to manage them. So I know there is interest because they understand that providers establish data in a specific way and to report it out the same way, whether it's surveillance measurement or other kinds of reporting or research, would simplify the process for the providers and the vendors. So there is interest.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
To Gene's point, we're trying to stress the QDM, so that's the point. Any other thoughts, things we ought to be thinking about, other use cases that may be relevant? Okay, well we're well through the meeting time so if you have any others send them to Floyd, to me, or to Tom, and whoever you send it to will make sure all the others get it. Who is the contact person that they should send it to, you, Floyd?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
For the committee?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
There is an open comment period starting on Wednesday for the QDM, so we'll be happy to receive them. There is a commenting tool that will be available on our NQF Web site for that. That's probably the easiest way. If they're specific to the committee, that I'd have to leave to the committee.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
If it's specific to the workgroup send it to me or send it to Tom Tsang or send it to Judy Sparrow and we'll make sure it gets to the right place. I'm going to hold on the QDM contract management recommendations and first do the May 19th hearing, and then if we have time come back to the contract management recommendations. We are, together with the Policy Committee, what is it called, Quality Workgroup, chaired by David Lansky, are going to co-sponsor a hearing in D.C. on May 19th about the meaningful use one experience. As you know, that's part of our work product is to do enough analysis of the meaningful use one experience that it informs our thinking about meaningful use two and three as we do that.

I think the two things before us, so number one to identify stakeholder groups that should be represented. One that seems obvious to me, although it may not be right, is small practices in hospitals as distinct from larger organizations. Clearly, HIT manufacturers are relevant, and probably guideline developers, regulators, it probably hasn't affected patients and consumers enough yet, although that may be the case. So at any rate, for discussion, what are the stakeholder groups that we need to hear from, and then who are some specific panelists who would represent those groups? Discussion on that? Any stakeholder groups that are listed there that are irrelevant, not critical, or any that were missed that we really should hear from?

Eva Powell – National Partnership for Women & Families – Director IT
I think that your mentioning the small practices and hospitals in rural facilities is certainly key to hear what's happening with them, since it's oftentimes hard to get feedback about them. With regard to the patient experience, you may be right, it's a little early to be seen, but I think it's important to include somehow. I'll be thinking through how to do this from the testimony at the hearing primarily because taxpayer incentives are paying for these and it's a short program, and certainly, a third of the way through there should be some evidence that patients are benefiting from this taxpayer money. So I think it would not be right to keep that perspective out of this hearing potentially because if there really is no indication that patients are seeing a benefit, then I think that's a huge signal to those of us working on meaningful use, that there's something we need to fix about the program.

There are a number of folks that are collecting patient stories and provider stories also, and that might be a good source for people to have at the hearing in terms of giving testimony. I know that Josh Seidman over at ONC is collecting provider stories and we hear the national partnership are working to collect patient stories, although certainly, as you said, we're not finding a lot of those yet, but we're just getting going. So hopefully soon we'll hit some treasure troves. We're also trying to work together with providers who have adopted technology to target them instead of just the broad population who obviously doesn't have exposure to these quite yet.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
That may actually be the place to get patient vignettes is from providers who may be aware of the source of the improvement, whereas, the patients might not be aware of the source.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Jim, I know that there are some people, and I know Golden Living, with the Indiana HIE and with Regenstrief, has some interconnectivity where we're working on the patient summary, transition of care, and I would like to recommend that at least one person, or maybe I can get somebody from home care, but from skilled nursing facilities comment. Because we're all trying to do meaningful use, even though we're not really in the legislation we're trying, especially on some of the more transition of care type of meaningful use objectives we are working on, and I know we can find, through Regenstrief and Indiana, somebody to talk on that. But I can look to see if there's somebody in home care that can at least have those two represented on the meaningful use ....

Rosemary Kennedy
I just want to support that recommendation in terms of the patient home care and long-term care. Patients are receiving clinical summaries and I'm finding with the project that I'm working on now quite vocal in terms of the kinds of information that's on it and tend to proactively identify some things that maybe are not on it and pointing it out to providers. I think it may be an interesting perspective and not typically tied directly to, well, I guess it is, to meaningful use stage—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Sure. No, that's a great point. I think that we clearly need to include them. I don't have RECs on this list. I assume RECs are also an important source of information.

Rosemary Kennedy
As well as the developers, you have guideline developers, but maybe the folks within the organizations that are implementing meaningful use in stage one, it may be interesting to get their feedback in terms of lessons learned.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Other thoughts?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
Perhaps professional associations like AMA or AHA or MGMA or other groups like that, larger organizations come in a lot of varieties, so integrated health systems vis-à-vis hospital systems, for-profit, not-for-profit hospital systems, and I was wondering about organizations like QIOs or regional information exchanges. As far, Jim, as speakers, there's a new person, David Gifford, M.D., he used to be a professor at Brown University and then head of the whole health system in Rhode Island, was one of the starters of the QIO program and he's now Head of Quality Assurance for the American Health Care Association.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Will the folks invited be asked to target their comments on the quality measure reporting component of meaningful use, or any aspect of meaningful use?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
We're selfish. We're interested in the quality measure aspects.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I just want to make sure we guide folks that way, because there will probably be limited time.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. That's a good point. The other thing is that we really want to hear about issues, it's the absolutely right thing to do, and all kinds of ways it's going well, but what we're looking for are issues that we need to address, not encomiums. Any other individual panelists that would be potentially useful?

Aneel Advani – Indian Health Service – Associate Director Informatics
I think Terry Cullen, our CIO, would be... in getting feedback from our perspective as well.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I'll tell you what, John and Aneel both, would you just send me those names e-mail so that I don't have to mangle them, and whatever contact information. That would be great.

Aneel Advani – Indian Health Service – Associate Director Informatics
Sure.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Yes, sir.

Rosemary Kennedy
We'll send them to you if we, after the call, come up with either stakeholders or specific individuals, we'll just send an e-mail?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, absolutely. This is one of those things that right after we sign off you're going to think of someone. So please just send them to us. We need them as soon as possible obviously to get them scheduled, but as soon as you think of them let us know. Obviously, we're interested in people who will not be afraid to tell us the truth, but they need to tell it to us in a way that we're going to be able to do something with it also, so it needs to be fact-based, ideally with some ideas about methods for improvement, those sorts of people.

W
I could add measure developers. I know we, I'm sure many others, are getting comments back from those trying to use measures in MU two.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, absolutely. Thank you. Okay, any other? Then we probably have five minutes before the public comment time. Floyd, why don't you tell us what kinds of things you can imagine in terms of this workgroup's recommendations to ONC about managing the QDM contract? Would it be things like making sure that resources for curation of the model are included in the contract in the management? What kinds of things do you imagine this is addressing? Tom Tsang, I guess, you also, if you could just give us, very briefly, how you see this functioning maybe we can provide you some useful feedback.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Actually I'd be interested in ... added to the agenda what actually feedback you're looking for. From my standpoint, our concerns are we can develop a quality data model, but there are some areas that require some harmonization in standards that I was hoping this workgroup could help clarify and move up to the Standards Committee to recommend work that needs to be done. But that's not NQF, that's work around ....

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Okay. Tom?

Tom Tsang – ONC – Medical Director
Yes, Jim, can you hear me?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, thanks. I'm sorry, Tom. I can't hear you now. You're breaking up.

Tom Tsang – ONC – Medical Director
I'm sorry. The line isn't very good here, but basically just adding to what Floyd said, we really want to make sure that the standards infrastructure is aligned with the QDM model. I think, for example, as we looked at some of the stressors on the Excel spreadsheet, the ... such notions like the risk management, risk assessment, and the clinical prediction rule. We want to make sure that the QDM model provided that level of capability and to make sure that as we develop standards and vocabulary sets that we would harmonize that process along as well.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Okay, great. If anyone has any comments, we have three minutes before the public comment period. I think, at least in my mind, the thing here is for us to start thinking about off line what kinds of harmonization and standards activities would be relevant, how the incorporation of risk assessment tools of various sorts into the model, how that would work, and then other things that you identify. I'm guessing that part of the issue here is to help ONC create a contract that provides NQF incentives and resources for continuing to expand and deepen the QDM. Any thoughts on that at all?

Maybe that's something to consider, Tom, is I know Floyd and the group have worked hard on making this represent the healthcare team. But my guess is that as a sector, our thinking about the team is so primitive that it probably bears special calling out, in terms of thinking of how the QDM would function as we try to have measures that reflect the involvement of more and more participants, patients, patient's personal caregivers, case managers, first responders. So that as time goes on NQF has the resources to continue to do what they've done beautifully, which is to have a tool that will let us represent increasingly well thought out care processes that involves contribution and communication needs of increasing numbers of people.

Rosemary Kennedy
I just wanted to add another comment to that. Our thoughts and definitions of the healthcare delivery team is certainly evolved and maybe somewhat primitive, I think that's a strong word, it's not the word to use, but—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think it is the word. I would say that's a good, accurate word anyway. Go ahead.

Rosemary Kennedy
The other side, use of the electronic health record for quality measurement and performance measurement is somewhat primitive, I can't find the right word, but it's certainly evolving, and that we can't look to the QDM to do everything. One area that comes to mind is the ability of the data and measuring all that, which even comes before the QDM. So it probably raises, or will raise issues in things that we just haven't yet discovered because we just started the process. If the data aren't valid as they're entered in the EHR, they could fit the QDM ... measurement, but yet we could have some issues there.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
That's an interesting point. So, Floyd, there are some data in health records that are widely known to be need to be taken with a grain of salt, and others that have very high sensitivity and specificity. For instance, if the patient has CHF, heart failure on their problem list, there's a fair chance that they don't have heart failure, whereas, others are much tighter. Does the QDM have or need any way to represent the confidence intervals of different kinds of data?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Jim, I really appreciate the question, because I understand and I recognize the issues. The QDM, and I think it comes back to the statement about evidence, the QDM has a way to describe what you want and when you're a measure developer, a guideline developer, and there's a way to specify it in such a way that you can be really careful that you only get what you're looking for.

With that said, if you specify to that level you may not have much data in the EHR. So when you talk about ejection fraction you can specify ejection fraction, you can specify the value, you can even specify which study that you're looking for if there are four different kinds of studies and one has preference to the others, even if it's not the latest value you can specify all of that with a .... The issue is on the confidence limits and which is the best one to choose, that's an evidence issue. So what I'm hearing is a lot of discussion about the implementation standardization and that's not so much a QDM definition, it's how can we make sure that EHRs are certified to maintain data in a certain way and that they are being implemented meaningfully to manage data in that way. So it is relevant to the QDM clearly, but I think we may be expecting too much of the QDM model.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think you're right, Floyd. I think that's back to what we said before, so we just need to be explicit that that's part of the input into the QDM, it's not part of the QDM itself.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Or I could say it's part of the learnings from QDM that need to be applied to implementation.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, okay. Great.

Tom Tsang – ONC – Medical Director
Jim, can I just make a suggestion that perhaps Floyd and I work together finishing out the Excel spreadsheet and at least share with the workgroup over the next two weeks to map out the five notions, the five stress notions to make sure that the QDM satisfies those stressors. So for example the notion of patients' health reported outcomes, the delta measures, the measurement across settings of care.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Right, and I think the other thing that came up today was that Floyd was going to put in a population management case and run that through and probably bring that back to the workgroup. Was that your understanding, Floyd?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
That wasn't my understanding. My understanding based on Chris Chute's comment was population based is usually an aggregate of individual results, so that it's not actually part of the measure. If there is a different takeaway, and there is something I have to deliver back, I need to have that clarified.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
That's another scope clarification also, that the QDM would feed into population management calculation, not have it resonant within it.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI
Because we're coming out of the framework of electronic health records it's probably fair to assume that the populations of first interest are defined clinically, so it could be a primary care population or it could be a population of people with heart failure, or a population of people who are in palliative care. But I think the first issue on population health because it's in the context of electronic health records is our clinical population as opposed to geographically defined populations.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Gene, I thank you for that comment. I think I can provide you a fairly straightforward example to try to show how QDM can address a population, preferably addressing a health department or an ACO or something other than just a ...practice.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Great.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
.... If that's what you want, I understand.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, and then I think if that's an exemplification of this is what QDM does, this is what's outside QDM. Clearly part of what we need to do is get clear for everybody what the boundaries are and then the expectations make more sense. Okay, we're at 12:27. Judy, can we open to public comment then?

Operator
We do have public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Could you go ahead and identify yourself, please?

Carol Bickford – ANA – Senior Policy Fellow
This is Carol Bickford at the American Nurses Association. In the stakeholder conversation for the upcoming meaningful use experience discussion, please incorporate public health, some state entities, someone perhaps with registry use or the developing registries, and then of course the health information exchanges.

Judy Sparrow – Office of the National Coordinator – Executive Director
Anybody else for a comment?

Beth Feldpush – American Hospital Association – Senior Associate Director for Policy
Hi. This is Beth Feldpush from the American Hospital Association. I just wanted to add that we are very open to and would help fill that panel. We do think that hospitals should be represented, and a range of hospitals, not only small providers, but urban rural and larger folks and folks involved in systems as well, and we would be more than happy to offer our services to help you get in touch with some folks.

Judy Sparrow – Office of the National Coordinator – Executive Director
Any other comments?

Operator
We have no more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, everybody. Thank you, Jim and Karen.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bye.

Public Comment Received During the Meeting

1. Will this be an update to the Guide for Reading EP and Hospital Measures Dec 2010?